STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 06/21/2012
	PROVIDER OR SUPPLIER	11755	ADDRESS, CITY, STATE, ZIP CODE  N MICHIGAN RD  VILLE, IN 46077	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	1	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
R0000				
	This visit was for a State Residential Licensure survey. This visit included the investigation of Complaint IN00109927.  Complaint IN00109927: Substantiated. State Residential deficiencies related to the allegations are cited at R52, R53, R214, and R217.  Survey dates: June 18, 19, 20, and 21, 2012  Facility number: 012263 Provider number: 012263 AIM number: N/A  Survey team: Janet Stanton, R.NTeam Coordinator Heather Lay, R.N. Melanie Strycker, R.N.  Census bed type: Residential108 Total108  Census payor type: Other108 Total108  Sample: 10  These State Residential findings are cited	R0000	The statements made in this of Correction are not an admission to and do not constitute an agreement with alleged deficiencies herein. Tremain in compliance with all federal and state regulations, community has taken or is planning to take the actions s forth in the following Plan of Correction. All alleged deficiencies cited have been are to be corrected by the dat dates indicated.	the Fo the et

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 1 of 70

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMP 06/2	COMPLETED 06/21/2012	
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO N MICHIGAN RD	ODE	
HEARTH	AT TUDOR GARD	ENS LLC		/ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	in accordance wi	ith 410 IAC 16.2.				
		ompleted 6/28/12				

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 2 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED		
			B. WIN			06/21/	2012
	PROVIDER OR SUPPLIER			11755	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD VILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0036	resident's physilegal representation noticed: (1) a significant of physical, mental, (2) a need to alteris, a need to discontreatment due to commence a new Based on record facility failed to physician and leg significant change physical status. Affected 1 of 1 resident affected 1 of 1 resident affected 1 of 1 resident #C]  Findings include  On 6/18/12 at 10 facility's locked to initiated with L.F.  At that time, Resident as non-interview falls requiring state activities of daily  On 6/20/12 at 6:0 record was review	ust immediately consult the cian and the resident 's give when the facility has decline in the resident 's or psychosocial status; or extreatment significantly, that continue an existing form of adverse consequences or to w form of treatment.  The deficient practice are in the resident's gal representative for a ge in the resident's The deficient practice are in the resident practice are in condition in a dents reviewed.  The deficient practice are in the resident practice.	R00	036	1. Resident's physician and le representative will be notified in the event of a significant declir in resident's physical, mental, psychosocial status or a need alter treatment significantly. 2 random audit of 11 out of 108 charts was completed to revie change of condition status updates. Notification of resident's physician and the resident's legal representative was noted. 3. An in-service (attachment A) was performed our nursing staff to review chard of condition status and proper notification of resident's physiciand the resident's legal representative. 4. Monthly monitoring of our change of condition procedure will be do by our Director of Nursing. Director of Nursing will report findings during the QA meeting quarterly.	in ne or to . A w	07/09/2012

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 3 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
			B. WIN			06/21/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			N MICHIGAN RD		
HFARTH	AT TUDOR GARD	FNSTIC			/ILLE, IN 46077		
							Q15)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
IAG			-	IAG			DATE
	dementia, hypertension, and history of cerebral vascular accident [stroke] with left-sided hemiplegia.						
	Resident #C was admitted to the facility						
	assisted living or	n 1/16/12 and to the					
	facility's locked [dementia] unit on 2/15/12.						
	A "Pre-Admission	on Assessment and Care					
	Plan for Indiana Assisted Living						
	Facilities" dated 12/21/11, no time,						
	•	s not limited to, "Fall					
	Risk: Services F						
	wheelchair prima	ary mode of					
	transportation ab	ole to ambulate with					
	walker Indeper	ndent with ambulation					
	Requires escort t	to most daily meals,					
	_	tings High [fall risk]					
		Resident #C] Independent					
		Requires occasional					
	assistance and or						
		cucing [with					
	transfers}"						
		27					
		gress Notes" dated					
		P.M., included, but was					
	not limited to, "F	Resident requires assist of					
	2 to bathroom ar	nd returned to bed					
	Resident unable	to stand or assist with					
	transfers increa	ased confusion Action					
		l Nursing Assistant					
		alified Medication Aide					
		oted unsuccessfully to					
	reorient resident	[Resident #C] C.N.A.					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 4 of 70

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  11755 N MICHIGAN RD  ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	to toilet resident during transfers. [#C] remained at confusion no P medications] ava agitation"  No documentation Resident #C's clinotification of he [legal representation increased agitation assistance with the A "Nursing Programmer P	on was located in nical record regarding er physician or daughter tive] regarding her on and need for total ransfers.  The series of the serie						

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 5 of 70

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	COMI 06/2	COMPLETED 06/21/2012				
	ROVIDER OR SUPPLIER	DENS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE  11755 N MICHIGAN RD  ZIONSVILLE, IN 46077					
	AT TUDOR GARD SUMMARY S (EACH DEFICIEN		11755	N MICHIGAN RD	CTION JLD BE	(X5) COMPLETION DATE		

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 6 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			A. BUILDING B. WING		06/21/2012	
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC		SVILLE, IN 46077		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
R0052	410 IAC 16.2-5-1					
	Residents' Rights - Offense  (v) Residents have the right to be free from:  (1) sexual abuse;  (2) physical abuse;  (3) mental abuse;  (4) corporal punishment;  (5) neglect; and					
	(6) involuntary se	eclusion.				
		ew and record review, the	R0052	This allegation of abuse was investigated per facility protocol	<b> </b>	
	*	ensure 1 of 1 residents		It was the determination of th		
	was free from ph	ysical abuse from 1		facility after investigation that		
	C.N.A.; for 1 of 3	3 residents reviewed for		physical abuse did not occur		
	allegations of ph	ysical abuse in a sample		related to this incident. 2. C	ther	
	of 10 residents reviewed. [Resident #K;			residents' safety was maintair		
	C.N.A. #5; Hous	-		by the facility following the ab		
	$C.IV.A. \pi 3, 11003$	ексереі #4]		prevention policy and procedu	ıre.	
	F: 1: : 1 1			3. A review of the abuse	uraa	
	Findings include	:		prevention policy and procedule was completed. An abuse	nes	
				in-service was scheduled for a	all	
	1	nt reported to ISDH on		staff members to attend. This		
	5/28/12 was revi	ewed on 6/15/12. The		in-service will be offered at		
	incident involved	l Resident #K and		multiple convienient times to		
	C.N.A. #5. The	report included, but was		ensure all staff are able to		
		e following information:		attend on or before 7/20/12.	,	
				4. Reporting of all allegations	OT	
	Date of Alleged	. 5/27/12		suspicious activity whether defined as abuse or not will be	Δ	
				expected by all staff members		
		of Incident: Resident		Any staff members failing to		
	-	as seated in the dining		follow our abuse prevention p	olicy	
	room after break	fast. C.N.A. [C.N.A. #5]		and procedures will recieve		
	was attempting to	o get resident up and		disiplinary action. Any allegat	ions	
	back to her room	. Housekeeper		of abuse will be immediatly		
		witnessed C.N.A.		reported to the appropriate		
		dent's arm and teller her		agencies including the		
		your a in the room.'		Indiana State Department of Health. Any allegations of abu	190	
	wan unun get y	your a in the room.		will be discussed during the		
				quarterly Quality Assurance		

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 7 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
			B. WIN			06/21/2012	
NAME OF I	DOLUBER OR GURRU IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		11755	N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC	ZIONSVILLE, IN 46077				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	_	up] 6/1/12: C.N.A. [#5]			committee meeting ongoing.		
	resigned during the course of the investigation.						
	True a of Injury	None					
	Type of Injury: None						
	Immediate Action Taken: Resident						
	assessed head to toe for signs of physical						
	abuse. C.N.A. was suspended pending						
	investigation."						
	At the survey entrance conference on						
	6/18/12 at 10:00	A.M., the Director of					
	Nursing was req	uested to provide all of					
	the investigative	documentation available					
	that had been co	mpleted for this incident.					
	On 6/20/12 at 7:	30 A.M., the					
	Administrator pr	ovided a folder					
	containing writte	en statements from					
	C.N.A. #5, Hous	sekeeper #4 and Q.M.A.					
	#3.						
	The statement fr	om C.N.A. #5 was dated					
	5/30/12, and ind	icated "On [Saturday-					
	-with a line cross	sed through it],					
	Sunday" The	re was no information in					
	the statement rel	ated to an incident on					
	5/27/12.						
	A statement from	n Housekeeper #4 was					
		id indicated "On 5/26/12,					
		s name] observed [C.N.A.					
	-	a patient out of the chair					
	5 5	a parietti out of the chair				ĺ	

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 8 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
			B. WINC		<del></del>	06/21/	2012
			p		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC			/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<del>                                     </del>	ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	in KSV [Keepsa	ke Villagethe					
	secured/locked Alzheimer's unit] activity						
	room, squeezing her arm stating 'Wait						
		in the room.' The					
	patient was screaming and yelling 'STOP.'						
	That's when I exited the room."						
	A statement from Q.M.A. #3 was dated						
	1						
	5/27/12 at "approximately 1:30 P.M."						
	The statement indicated "Said writer went						
	on break with housekeeper name						
	[Housekeeper #4's name].						
	[Housekeeper's r	name] looked at me and					
	became nervous	and said [Q.M.A. #3's					
	name], I want to	say something but I'm					
	afraid. I said wh	nat's wrong, she then					
	began to say, I d	on't think it's right for					
		s to mistreat people. I					
		ı mean. She said I don't					
	1	k to and I went home last					
		orry me because I seen it					
		-					
		today. I asked her what					
	-	e said well that aide name					
	-	ne] pinched [Resident					
		erday and today and					
	yesterday he tolo	l her wait till you get your					
	a in the room	n. I can't do anything to					
	you cause the ca	mera is out here. With					
	1 -	ly told [Unit Manager's					
	name]"	5 5 5					
	During the daily	conference on 6/20/12 at					
		Administrator was given					
	•	to submit any other					
	and opportunity t	o saomit any onici					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 9 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
			A. BUIL B. WING			06/21/	/2012
			B. WINC		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	S.			N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	ENS LLC			'ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	cumentation related to					
		an interview at that time,					
		Housekeeper had					
		rvice on abuse and was					
	-	orting requirement, but					
	during his interview with her, she had told						
	him that she was						
		dicated he counseled the					
	-	d stressed it was not her					
	call to decide wh						
	abuse, but her responsibility to report anything suspicious.						
	On 6/21/12 tha	Administrator provided					
	-	entation for the incident.					
		-page typed summary,					
	1	Administrator as					
		n, included, but was not					
	innited to, the io	llowing information:					
	"I was notified o	n Sunday, May 27, 2012					
	about an inciden	t that happened on					
	Saturday, May 2	6, 2012 I immediately					
	suspended [C.N.	A. #5' name] pending					
	investigation into	the allegations I met					
	with [Housekeep	er #4's name] on					
	Monday, 5/28/11	_					
	[Housekeeper #4	's name] repeated her					
	_	old me that she did not					
	know for sure w	hat she saw was a					
	problem until she	e went home and slept on					
	•	led to see how other staff					
	members handle	d resident [Resident #K's					
	name]. It was no	ot until seeing others with					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 10 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/21/2012				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11755 N MICHIGAN RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION			
	that she felt [C.N mistreated her. I [Housekeeper #4 abuse reporting I know that it is not judge guilty or n responsibility to if she thinks som done to a resider.  I met with [C.N. at 11:15 A.M. [Greluctant to complete feared termination refusing to talk the guilty. He agree investigation. He statement. He samistreat anyone inappropriately that the housekee had a personal guilty. I checked the carsuspicious activity abnormal was not camera footage  The conclusion of to NO conclusive the incidents in the substantiated residues.	I's name] on the proper procedure. I also let her of her responsibility to ot, but it is her inform the administrator nething is inappropriately at.  A. #5's name] on 5/30/12 C.N.A. #5's name] was e in and talk because he on. I made it clear that o me made him appear d to come in for the e provided a written aid that he did not and has never spoken o a resident. He was sure eper did not like him and rudge against him  mera footage to see if any ty was recorded. Nothing oted on available security  of the investigation leads e physical evidence that						

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 11 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	G		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
TWINE OF I	ROVIDER OR SOLVER				N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		dents were present did					
	_	#5's name] did resign his					
	^	fore any formal reprimand					
		He stated this untrue					
	_	ll as many other reasons					
	for his resignation."						
	Following the entrance conference on						
	6/18/12, the Director of Nursing provided						
	the facility's Abuse Prevention Policy and						
	Procedure, dated as revised on 9/7/11.						
	The Policy outlined "Definitions of						
	· ·	ion of Abuse," "Worker					
	Responsibilities,	" and "Documentation."					
	The section for "	'Definitions of Abuse"					
		owing: "Physical Abuse-					
		ain or injury which is					
		d upon an elder by a					
		care or custody of, or who					
	*	n of trust with that elder,					
	•	ical abuse. This includes,					
		d to, direct beatings,					
		nreasonable physical					
	•	olonged deprivation of					
	food or water	oronged deprivation of					
	100 4 01 1/4001						
	Psychological/En	motional AbuseThe					
		of mental suffering by a					
		ion of trust with an elder,					
		nological/emotional					
		es of such abuse are:					
	•	reats, instilling fear,					
	· ·	midation, isolation of an					
	1	,	1				I

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 12 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	onstruction 00	COME	E SURVEY PLETED	
			B. WING		06/2	1/2012
	PROVIDER OR SUPPLIEF		11755	NDDRESS, CITY, STATE, ZIP COI N MICHIGAN RD VILLE, IN 46077	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	elder"					
	9/27/11 with a re The addendum in limited to, the fo "Screening Proto have criminal ba immediately upo	ed an approval date of eview date of 4/11/12. Included, but was not ellowing information:  Ocol: All employees will eckground checks on hiring				
	suspected abuse resident, visitor resident, every e persons involved potential for add implemented  Investigations: I suspected abuse will be conducted Director, Director Office Manager, investigation will placing any involved.	I include immediately lived staff on eave, interviewing all				

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 13 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	G		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUPPLIER			11755 I	N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	umentation of interviews					
		resolve the calm as soon					
		allegations will be					
	reported to the co	ompany, as well as all					
	applicable state a	and federal agencies.					
	Reporting: Emp	loyees will report all					
		ay be considered abuse or					
		lent from any and all					
	_	ts of suspected or					
	_	or neglect must be					
	presented immed	_					
	Administrator	-					
	7 Millinistrator						
	Ingarijaag on "A	buse Prevention," using					
		. •					
		icy and Procedure, were					
		16/12 and 4/20/12. The					
	_	In Sheet" for the inservice					
		isted a signature for					
	attendance by C.	N.A. #5.					
		. 1 01 48 0 4					
		ign-In Sheet" for the					
		0/12 listed a signature for					
		oth C.N.A. #5 and					
	Housekeeper #4.						
	This State Resid	ential tag relates to					
	Complaint IN00						
	Complaint 11100	1V//41.					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 14 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIG	00	COMPLETED	
				LDING	<del></del>	06/21/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
UEADTU	AT TUDOD CADD	TNS II C			N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC		ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0053	410 IAC 16.2-5-1						
Residents' Rights - Deficiency							
		ive the right to be free from					
	verbal abuse.						
	Based on interview	ew and record review, the	R00	)53	This incident was investigated.		07/20/2012
	facility failed to	ensure 1 of 1 residents			by the facility according to stat		
	•	rbal abuse from 1			guidelines and the facilities ab		
		3 residents reviewed for			prevention policy and procedu	re.	
	·				The conclusion of that investigation was that there was	26	
	_	rbal abuse in a sample of			no evidence to substantiate th		
		ewed. [Resident #K;			verbal abuse allegation. 2. O		
	C.N.A. #5; Hous	ekeeper #4]			residents' safety was maintain		
					by the facility following the abu	ıse	
	Findings include	• •			prevention policy and procedu	re.	
					3. A review of the abuse		
	A facility incider	nt reported to ISDH on			prevention policy and procedu	res	
	•	ewed on 6/15/12. The			was completed. An abuse	ш	
					in-service was scheduled for a staff members to attend. This	III	
		l Resident #K and			in-service will be offered at		
		report included, but was			multiple convienient times to		
	not limited to, the	e following information:			ensure all staff are able to atte	end	
					on or before 7/20/12. 4.		
	"Date of Alleged	: 5/27/12			Reporting of all allegations of		
	Brief Description	n of Incident: Resident			suspicious activity whether		
	[Resident #K] wa	as seated in the dining			defined as abuse or not will be		
		fast. C.N.A. [C.N.A. #5]			expected by all staff members		
					Any staff members failing to follow our abuse prevention po	olicy	
		o get resident up and			and procedures will recieve	лісу	
	back to her room	•			disiplinary action. Any allegation	ons	
		] witnessed C.N.A.			of abuse will be immediatly		
		dent's arm and teller her			reported to the appropriate		
	'Wait until I get y	your a in the room.'			agencies including the Indiana		
					State Department of Health. A	ny	
	Per F/U [follow-	up] 6/1/12: C.N.A. [#5]			allegations of abuse will be		
	resigned during t				discussed during the quarterly		
	investigation.	ne course of the			Quality Assurance committee meeting ongoing.		
	mvesugation.				The string originity.		

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 15 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING	NSTRUCTION 00	(X3) DATE COMPI				
			A. BUILDING B. WING		06/21	/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  11755 N MICHIGAN RD  ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	Type of Injury:	None						
	assessed head to	on Taken: Resident toe for signs of physical was suspended pending						
	6/18/12 at 10:00 Nursing was req the investigative	trance conference on A.M., the Director of uested to provide all of documentation available mpleted for this incident.						
	5/30/12, and ind -with a line cross Sunday" The	om C.N.A. #5 was dated icated "On [Saturday-sed through it], re was no information in ated to an incident on						
	dated 5/26/12 and I [Housekeeper's #5's name] grab in KSV [Keepsa secured/locked A room, squeezing	n Housekeeper #4 was d indicated "On 5/26/12, s name] observed [C.N.A. a patient out of the chair ke Villagethe Alzheimer's unit] activity her arm stating 'Wait a in the room.' The						

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 16 of 70

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
			B. WIN			06/21/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	R			N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC			/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	aming and yelling 'STOP.'					
	That's when I ex	ited the room."					
	A statement fron	n Q.M.A. #3 was dated					
	5/27/12 at "appro	oximately 1:30 P.M."					
		dicated "Said writer went					
	on break with ho						
	[Housekeeper #4	-					
	1 - 1	name] looked at me and					
		and said [Q.M.A. #3's					
		say something but I'm					
	1	at's wrong, she then					
		•					
	"	on't think it's right for					
		s to mistreat people. I					
		mean. She said I don't					
		k to and I went home last					
	•	orry me because I seen it					
	happened again t	today. I asked her what					
	did you see. She	e said well that aide name					
	[C.N.A. #5's nan	ne] pinched [Resident					
	#K's name] yeste	erday and today and					
	yesterday he told	l her wait till you get your					
		I can't do anything to					
		mera is out here. With					
	*	ly told [Unit Manager's					
	name]"	J [					
	During the daily	conference on 6/20/12 at					
	1	Administrator was given					
		o submit any other					
		-					
	_	cumentation related to					
		an interview at that time,					
		Housekeeper had					
	attended the inse	rvice on abuse and was					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 17 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN	G		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
WHILE OF 1	ROVIDER OR SOLVER				N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	DENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<b>†</b>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		orting requirement, but					
	_	iew with her, she had told					
	him that she was						
		dicated he counseled the					
	^	d stressed it was not her					
		nether or not there was					
	· ·	sponsibility to report					
	anything suspici	ous.					
	On 6/21/12 the	Administrator provided					
		entation for the incident.					
		-page typed summary,					
	· ·	Administrator as					
	1	m, included, but was not					
		ollowing information:					
	innited to, the fo	moving information.					
	"I was notified o	on Sunday, May 27, 2012					
		t that happened on					
		6, 2012 I immediately					
		A. #5' name] pending					
		o the allegations I met					
	_	per #4's name] on					
	Monday, 5/28/11	——————————————————————————————————————					
	•	I's name] repeated her					
	-	told me that she did not					
		hat she saw was a					
		e went home and slept on					
	^	led to see how other staff					
		d resident [Resident #K's					
		ot until seeing others with					
	_	nt K's name] on Sunday					
	_	N.A.#5's name] had					
	mistreated her.	-					
		t and counser t's name] on the proper					
	Lilousekeepei #2	rs name on the proper					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 18 of 70

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMPL 06/21	LETED			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 11755 N MICHIGAN RD ZIONSVILLE, IN 46077					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	know that it is no judge guilty or n responsibility to	inform the administrator nething is inappropriately						
	at 11:15 A.M. [6] reluctant to come feared termination refusing to talk the guilty. He agreed investigation. He statement. He samistreat anyone inappropriately that the housekers	A. #5's name] on 5/30/12 C.N.A. #5's name] was e in and talk because he on. I made it clear that o me made him appear d to come in for the e provided a written aid that he did not and has never spoken o a resident. He was sure eper did not like him and rudge against him						
	suspicious activi	mera footage to see if any ty was recorded. Nothing oted on available security						
	to NO conclusive the incidents in the substantiated responsion that an impade while residuate occur. [C.N.A. # position here before the position here before the properties of	of the investigation leads e physical evidence that his report were ident abuse. It is my nappropriate comment lents were present did #5's name] did resign his fore any formal reprimand He stated this untrue						

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 19 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE COMPI 06/21	LETED	
	PROVIDER OR SUPPLIER		11755	ADDRESS, CITY, STATE, ZIP COI N MICHIGAN RD /ILLE, IN 46077	DE _	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	allegation as well for his resignation	l as many other reasons n."				
	6/18/12, the Dire the facility's Abu Procedure, dated The Policy outlin Abuse," "Indicat	trance conference on ector of Nursing provided ase Prevention Policy and as revised on 9/7/11. ned "Definitions of ion of Abuse," "Worker " and "Documentation."				
	included the follo- Any physical pa willfully inflicted person who has of stands in position constitutes physical but is not limited sexual assault, un	Definitions of Abuse" owing: "Physical Abuse- nin or injury which is d upon an elder by a care or custody of, or who n of trust with that elder, cal abuse. This includes, to, direct beatings, nreasonable physical clonged deprivation of				
	willful infliction person in a posit constitutes psych abuses. Example verbal assault, th	motional AbuseThe of mental suffering by a ion of trust with an elder, cological/emotional es of such abuse are: reats, instilling fear, midation, isolation of an				
	An addendum, ti Management Ab					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 20 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPLETED	
			B. WING			06/21/2012	
NAME OF I	DROVIDED OD SLIDDI IED		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			11755 N	N MICHIGAN RD		
	AT TUDOR GARD				'ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	, The state of the	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
TAG		· · · · · · · · · · · · · · · · · · ·		IAG	BH ICH. C. I	DATE	
		d an approval date of					
		view date of 4/11/12.					
		ncluded, but was not					
	limited to, the fo	llowing information:					
	"Caraaning Drata	and: All amplayans will					
		col: All employees will					
	have criminal ba	· ·					
	immediately upo	n niring					
	Dravantion of ab	use training will be					
		•					
provided upon hiring and annual thereafter							
	thereafter						
	Protection of Res	sidents: In situations of					
		involving resident to					
	_	o resident or staff to					
	·	ffort to separate the					
		without increasing the					
	1 ^	C					
	_	itional danger will be					
	implemented						
	Investigations: I	n situation of reported or					
	_	neglect, an investigation					
		d by the Executive					
		or of Nursing, Business					
	Office Manager,	•					
		l include immediately					
	placing any invo	•					
	1						
		ave, interviewing all					
	persons pertinent						
	_	imentation of interviews					
		esolve the calm as soon					
		allegations will be					
	reported to the co	ompany, as well as all					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 21 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPL			ETED	
			B. WIN			06/21/	2012
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC			/ILLE, IN 46077		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		and federal agencies.					
	applicable state t	and rederar ageneres.					
	Reporting: Emp	loyees will report all					
		ay be considered abuse or					
		-					
	-	lent from any and all					
	•	ts of suspected or					
		or neglect must be					
	presented immed	-					
	Administrator	"					
	Inservices on "A	buse Prevention," using					
	the facility's Poli	icy and Procedure, were					
	conducted on 3/1	16/12 and 4/20/12. The					
		In Sheet" for the inservice					
	_	isted a signature for					
	attendance by C.	•					
	attendance by C.	N.A. #3.					
	The "Incervice S	ign-In Sheet" for the					
		_					
		0/12 listed a signature for					
		oth C.N.A. #5 and					
	Housekeeper #4.						
		ential tag relates to					
	Complaint IN00	109927.					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 22 of 70

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DINC	00	COMPL	ETED
			A. BUIL B. WING			06/21/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				N MICHIGAN RD		
HEADTH	AT TUDOR GARD	ENSTIC			/ILLE, IN 46077		
			ı		TIELE, IN 40077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
R0117	410 IAC 16.2-5-1						
	Personnel - Defice	sufficient in number,					
	· ,	id training in accordance with					
		laws and rules to meet the					
		hour scheduled and					
		eds of the residents and					
	services provide	d. The number,					
		nd training of staff shall					
	•	required to provide for the					
	•	f the residents. A minimum of					
one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the							
		receive residential nursing					
		nistration of medication, or					
	both, at least one	e (1) nursing staff person					
		at all times. Residential					
		er one hundred (100)					
	<del>-</del>	ly receiving residential					
	•	or administration of					
		oth, shall have at least one					
		rsing staff person awake and es for every additional fifty					
		ersonnel shall be assigned					
		s for which they are trained to					
		ee duties shall conform with					
	written job descr	iptions.					
	Based on intervio	ew and record review, the	R01	17	1. A training class for our nurs	ses	06/27/2012
		ensure that a minimum of			was held on 6/27/12 to meet the		
	•	person with both a			first aid requirement. 2. There	e is	
	-	lmonary Resuscitation			1 awake person onsite with		
	•				current CPR and First Aid certifications at all times. 3.		
	` '	Aid certificate, was on			Review of Policy and Procedu	ıres	
		in that 71 of 72 staff			requirement for first aid	50	
		have a current CPR and			certification. Business office		
	First Aid certific	ation. This deficient			manager will verify upon hire a	all	
	practice had the	potential to affect 108 of			employees with first aid		
	108 residents res	iding in the facility.			certification to ensure accurate	;	
		- ,			files are up to date. 4. The		
					number of staff members		

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 23 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			A. BUILDING B. WING		06/21/2012
				T ADDRESS, CITY, STATE, ZIP CODE	ı
NAME OF P	PROVIDER OR SUPPLIER	R .		N MICHIGAN RD	
HEARTH	AT TUDOR GARD	ENSTIC		SVILLE, IN 46077	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Findings include	:		currently CPR and First Aid	
				certified will be part of our	
	During daily con	aference on 6/19/12 at		quarterly QA meeting from	aura .
		rirector of Nursing was		6/27/12 ongoing. This will en proper staffing on each shift.	Suit
		vide documentation of all			
		tions, certifications, and			
	in-services.				
	On 6/20/12 at 8:0	00 A.M., the Vice			
	President of Ope	erations provided a binder			
	•	licenses, certifications,			
		id certificates. Review			
		nts at that time indicated			
		ember had current CPR			
	and First Aid cer	tificates.			
	During a daily co	onference on 6/21/12, at			
	3:00 p.m., the Di	irector of Nursing was			
	•	unity to provide the			
		Aid certifications for any			
		ntly employed. In an			
		time, she indicated the			
	facility's employ	•			
	•	ded CPR only and not			
	First Aid. The E	Executive Director			
	indicated he did	not know both were			
	required.				
	1				
			1		1

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 24 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DINC	00	COMPL	ETED
		A. BUIL B. WINC			06/21/	2012
		b. WINC		DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				N MICHIGAN RD		
HEARTH AT TUDOR GARDE	ENS LLC			'ILLE, IN 46077		
(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENC	Y MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG REGULATORY OR L	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0148  410 IAC 16.2-5-1. Sanitation and Sa (e) The facility sha grounds, and equi in good repair, and adversely affect the residents or the population of the continued upk (2) The electrical sappliances, cords sources, fire alarm shall be maintained functioning and concelectrical codes. (3) All plumbing shall be in the comply with state (4) At least yearly systems shall be in the facility failed to end functioning of the failed to establish maintenance of the deficient practice night door alarm as impact 81 of 108 mon-locked unit of the failed to establish maintenance of the deficient practice night door alarm as impact 81 of 108 mon-locked unit of the failed to establish maintenance of the deficient practice night door alarm as impact 81 of 108 mon-locked unit of the failed to establish maintenance of the deficient practice night door alarm as impact 81 of 108 mon-locked unit of the failed to establish maintenance of the deficient practice night door alarm as impact 81 of 108 mon-locked unit of the failed to establish maintenance of the deficient practice night door alarm as impact 81 of 108 mon-locked unit of the failed to establish maintenance of the deficient practice night door alarm as impact 81 of 108 mon-locked unit of the failed to establish maintenance of the deficient practice night door alarm as impact 81 of 108 mon-locked unit of the failed to establish maintenance of the failed to esta	all maintain buildings, ipment in a clean condition, d free of hazards that may ne health and welfare of the ublic as follows: hall establish and implement for maintenance to ensure seep of the facility. system, including systems, ed to guarantee safe compliance with state hall function properly and plumbing codes. The health gand ventilating inspected. The proper enight door alarm and a written program for the impacted 1 of 1 facility and had the potential to residents residing in the f the facility.	R014		1. On 6/21/12 the battery for the front door bell was changed. A operational check was complet to ensure proper function of the door and alerting system. An in-service was performed on 6/21/12 with the nursing staff to ensure proper knowledge of nighttime operation of the front door. (See Attachment C) 2. Weekly secure door operation checklist was expanded to include all secure doors function during different hours operation. This checklist will be performed by our maintenance staff. 3. Review of policy and procedures to include secure door operation. The front door and alert system were added to the weekly secure door operatichecklist. 4. Maintenance staff.	An ted e o t of be c o ion	06/21/2012

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 25 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUII	LDING	00	COMPLI	ETED
			B. WIN			06/21/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC			/ILLE, IN 46077		
					,	1	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		EBE BENTI TING IN GRAINTHON,		1710	will perform operational check		DATE
	facility.				on the secure doors to verify	·	
	0 (100/10 + 5 44 4 35 4 6 31)				proper operation during varyir	ıg 📗	
		44 A.M., the facility was			hours of operation. A review		
	notified by phon	e of need to enter the			the door operation audit will b		
	facility.				done at the QA meeting ongo	ng.	
	At that time, Licensed Practical Nurse #4						
unlocked the locked entrance door.							
	amounts are round entrained door.						
On 6/20/12 at 5:48 A.M., in an interview,							
		L.P.N. #4 indicated she knew nothing					
	about the "night door alarm" and how it functioned. She indicated all residents of						
	_	teys to the doors and					
		their individual keys					
		ce door was locked for the					
	night. L.P.N. #4	indicated when an					
	ambulance was o	called after hours [when					
	the doors are loc	ked] she would have					
	someone stand a	t the front door to let					
	them [ambulance	e personnel] in the					
	facility.						
	On 6/20/12 at 7:	30 A.M., in an interview,					
		irector indicated that					
		ce door alarm was					
	_	ned, the staff would be					
	alerted through t	neir pagers.					
	A de la companya de l	C :1:4 :44					
	· ·	facility written program					
		r alarm system was					
	requested.						
	On 6/20/12 at 12	2:00 P.M., the Executive					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 26 of 70

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMPL <b>06/21</b> /	ETED
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD	<u> </u>	
HEARTH	AT TUDOR GARD	ENS LLC		/ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	a written program door alarm and d maintenance log function of the a	d the facility did not have in place for the front lid not have any is for checking the larm; however, the front lid be added to all				

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 27 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE COMPL		
			B. WIN			06/21/	2012
	PROVIDER OR SUPPLIER			11755	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0154	(k) The facility shareas, common of utensils clean, from and maintained if with 410 IAC 7-2. Based on observer record review, the maintain equipmed manner in 1 of 1 practices had the 108 residents who kitchen.  Findings include  1. During the initial kitchen on 6-18-was observed to plastic containers inside of the bott moisture.  During an intervitorie price of Food items were clean air-dried after was a Chefmate for to contain food disurface.  During an intervitorie puring an	afety Standards - Deficiency hall keep all kitchens, kitchen dining areas, equipment, and ee from litter and rubbish, in good repair in accordance 4.  ation, interview, and e facility failed to ent in a clean, sanitary kitchen. These deficient potential to affect 108 of o ate meals from the  tial observation of the 12 at 10:15 a.m., a shelf contain two 8-quart clear is stacked together. The om container contained  tew at this same time, the Services indicated the . He indicated items are	R01	54	1. On 6/18/12 the containers were immediately separated for proper drying and storage. The food slicer was immediately cleaned as it is after every use. The skillet in question was discarded immediately. All distand utensils were checked for cleanliness. 2. Review of all kitchen equipment cleaning schedule was performed by our food service director. 3. Reviewed our kitchen sanitating policy and procedures. An equipment cleaning checklist winstituted to be performed and initialed by each shift. An in-service will be performed or 7/09/12 with our dietitian to ensure compliance. (See Attachment F) 4. The food service director will review kitched equipment cleanliness as need and report any discrepancies of the QA committee meeting quarterly and ongoing.	e.shes ur on was	06/21/2012

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 28 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
			B. WIN			06/21/	2012
			D. WII.		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENSTIC			/ILLE, IN 46077		
				<u> </u>	10077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	slicer is usually	cleaned after each use.					
	3. A shelf adjace	ent to the food					
	1	ater was observed to					
		ks of large and small					
		•					
		all skillet contained					
	-	due and felt greasy to					
	touch.						
	During an interv	iew at this same time, the					
	~	Services indicated this					
		iscarded. He then					
	discarded the ite	m into a trash receptacle.					
	Retail Food Est	ablishment Sanitation					
	Requirements Ti	tle 410 IAC 7-24"					
	effective 11/13/0	04 indicates the					
	following:						
	Tollowing.						
	"CEC 205 (a) E.	guinmant food contact					
	` ′	quipment food-contact					
		nsils shall be clean to					
	sight and touch.	(b) The food-contact					
	surfaces of cook	ing equipment and pans					
	shall be kept free	e of encrusted grease					
		er soil accumulations"					
	a openio ana em						
	and						
	anu						
	` '	fter cleaning and					
	sanitizing, equip	ment and utensils: (1)					
	shall be air-dried	l or used after adequate					
	draining as speci	•					
		Fore contact with food"					
	1 / 0.1010(a), 0c1	ore contact with food					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 29 of 70

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMP	COMPLETED	
			B. WING			1/2012
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO	DDE	
HEARTH	AT TUDOR GARD	PENSILC		N MICHIGAN RD /ILLE, IN 46077		
				, ILLE, IIV 70011		(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 30 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
			B. WIN			06/21/	2012
NAME OF F	ADOLUDED OD GLIDDLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	<b>C</b>		11755	N MICHIGAN RD		
	AT TUDOR GARD	ENS LLC		ZIONS	VILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0214	410 IAC 16.2-5-2 Evaluation - Defi	` '					
		n of the individual needs of					
	` '	all be initiated prior to					
	admission and s	hall be updated at least					
	,	d upon a known substantial					
	_	sident 's condition, or more					
	often at the resident 's or facility 's request.  A licensed nurse shall evaluate the nursing						
	needs of the resi	•					
	Based on observa	ation, interview and	R02	214	Created an admission		07/09/2012
	record review, th	ne facility failed to			summary form (See Attachme	nt	
	document the spe	ecific criteria used, a			D). This form ensures that all relevant information is gathered	ed	
	summary of info	rmation collected, and			to appropriately place a reside		
	the decision-mak	ring process used to			in our secure memory care,		
	demonstrate that	4 of 4 residents			Keepsake Village. 2. Review	of	
	reviewed, who re	esided on the Alzheimer's			all current Keepsake Village residents and completion of the	۵	
	unit, were approp	priately evaluated for			admission summary form. This		
	admittance to the				will be completed on or before		
		imer's secured/locked			7/9/12. 3. This new form will	be	
	unit: and failed to	o evaluate 1 of 1 resident			an evaluation tool for all new	alea.	
	· ·	l a change in condition.			resident admissions to Keepsa Village. This form will be	ake	
	•	affected 4 residents in a			completed by the nursing staff	:	
	sample of 10 resi				and reviewed by the Executive		
	[Residents #B, #				Director prior to admission. 4.		
	[residents #B, #	C, "D, and "II]			The nursing staff will complete	е	
	Findings include				this form prior to any new admissions for Keepsake Villa	ne	
	Tilldings include	•			The Director of Nursing will	90.	
	1. The clinical re	ecord for Resident #K			complete a quarterly audit of t	his	
		6/21/12 at 9:00 A.M.			form and present it to the quarterly QA meeting ongoing		
		s admitted directly to the			quarterly wa meeting ongoing	•	
		/locked Alzheimer's unit					
		was admitted from					
		tial-licensed facility that					
		cured/locked Alzheimer's					
	unit. Diagnoses	included, but were not	1		1		I

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 31 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	G		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
WHILE OF I	ROVIDER OR SOLVER				N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nced dementia with					
		to speak], history of					
	ulcerative colitis with chronic						
		vic cystic lesion,					
	1	disease, lower extremity					
	edema, and osteo	oarthritis.					
	On 6/21/12 at 9:23 A.M., the resident was						
observed ambulating with staff in the dining room. When approached, the							
resident smiled and began speaking. Her							
	communication was non-sensical with						
		ponses to simple					
		s "How are you?" She					
	^	•					
		nd pleasant, and staff					
	-	nand and directed her to					
	an activity in the	e lounge area.					
	An "Assessment	and Care Plan for					
	Indiana Assisted	Living Facilities" form,					
		e-Admission" and dated					
	4/9/12, included.	, but was not limited to,					
	the following inf						
	"No assistive de	vice (for mobility)-					
	-Independent for	ambulation;					
	_	g on pants has to go to					
	restroom. If deh	ydrated will become					
		esistive to showering-					
	-doesn't like; son	_					
	· ·	ular/sandwiches, finger					
		Loves sweets; wanders					
		irly checks; mumbles a					
		able to communicate with					
	1		1				I

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 32 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WING	3		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIER			11755 1	N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	lifficulty; responds to					
		estions; Current and Past					
	Behavioral Issues=Does like to carry a						
	doll with her. Comforted by holding						
	hand"						
	There was no int	formation on the					
	pre-admission as	ssessment form indicating					
		was appropriate for					
	admission to the facility's secured/locked						
	Alzheimer's unit.						
	Themen's diff.						
	A "History and I	Physical" form, completed					
	1	physician on 5/22/12,					
		pears to be transferring					
		cility. Requiring a					
		nere is little prior records					
		ent has aphasia with					
		tia. Unable to provide					
	any history."						
	There was no int	formation from the					
		d to how he determined					
		required a secured unit.					
	that the resident	required a secured unit.					
	A subsequent su	mmary of all information					
	•	vailable sources, and used					
		eed and appropriateness					
		admission to the					
		Alzheimer's unit, was not					
	found.	nzhemier s umt, was not					
	Touriu.						
	In an interview of	on 6/21/12 at 10:10 A.M.,					
		or indicated they did not					
	Silv i Idiiiiiiistidi	aroutou triej ara riot	I	l			

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 33 of 70

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUIL		00	06/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1710		tion documentation		1110			DATE
	_	sons residents were					
	admitted to the Alzheimer's unit. He						
	indicated they had a physician's orders,						
	and believed tha	t was sufficient.					
	2 Tour of the 1-	oolsad [damantic]itaa					
		ocked [dementia] unit was /12 at 10:30 A.M. with					
	L.P.N. #1.	12 at 10.30 A.W. with					
	At that time, in an interview with L.P.N.						
	#1, Resident #D	was identified as					
		le, with a history of					
		cent admission to the					
	geriatric psychia	•					
		obile with her walker,					
	and a history of	falls.					
	On 6/18/12 at 1:	45 P.M., Resident #D's					
		wed. diagnoses included,					
		ited to, dementia with					
	behavioral distu	rbances and					
	hypothyroidism.						
	Pagidant #D	s admitted to the facility's					
		n 2/13/12 and transferred					
	_	ocked [dementia] unit on					
	3/16/12.	[					
	Δ "Pre-Admissio	on Assessment and Care					
	Plan for Indiana						
	Facilities" dated	•					
	included, but wa						

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 34 of 70

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			B. WING		06/21/2012
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE	•
HEARTH	I AT TUDOR GARE	DENS LLC		5 N MICHIGAN RD SVILLE, IN 46077	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
IAG	"Mobility: Inde	<u> </u>	TAG		DATE
	ambulation	pendent with			
		nory/Cognitive Function:			
		nemory are not always			
	_	onitoring and guidance			
	and occasional r	redirection			
	Communication	: Usually able [to			
	communicate w	ith staff and understand			
	_	t and Past Behavioral			
	Issues: Easily w	vorried and anxious"			
	Thomas vyama ma a	other "Assessment and			
		diana Assisted Living			
		ed in Resident #D's			
	clinical record.	tu iii Kesiuciii #D s			
	cimical record.				
	A "Nursing Prog	gress Notes" dated			
	2/13/12, no time	e, included, but was not			
	limited to, "Resi	ident arrived [to assisted			
	living] alert to	person and place upset			
	with family ve	ery agitated"			
	Resident #D's m	ursing progress notes from			
		2/24/12 included notes			
	_	gitation and refusal of care.			
		,			
	A "Nursing Prog	gress Notes" dated			
	2/24/12 at 5:30 l	P.M., included, but was			
	not limited to, "	Resident [#D] sent to			
	1	or evaluation and			
	treatment"				
	A "Nursing Dro	gress Notes" dated			
	,	P.M., included, but was			

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 35 of 70

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COMP	E SURVEY LETED 1/2012
	PROVIDER OR SUPPLIEF		11755	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD /ILLE, IN 46077	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	not limited to, "I hospital"	Resident returned from				
	time, included, b	Orders" dated 3/16/12, no but was not limited to, e Hearth at Tudor [locked dementia]				
	#D's clinical rec	ras located in Resident ord regarding her teria for admission to the unit.				
	evaluation for ac	00 P.M., Resident #D's dmission to the locked ed from the director of				
	did not have an i	1:30 A.M., in an oN indicated the facility individual evaluation for Imission to the facility's				
	locked dementia L.P.N. #1 identifi non-interviewab	I tour of the facility's unit, in an interview, fied Resident #B as le with a recent change in ing ambulation and with injury.				
		2:55 P.M., Resident #B's ewed. diagnoses included,				

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 36 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
			B. WIN	G		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	DENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ited to, dementia and					
	cellulitis of the le	eft leg.					
		s admitted to the facility					
	-	cked dementia unit on					
	9/30/11.						
	A "Pre-Admission Assessment and Care						
	Plan for Indiana	Assisted Living					
	Facilities" dated 9/29/11, no time,						
	included, but was not limited to,						
	"Mobility: Ambulates independently,						
	transfers indeper	ndently Social Service:					
	Orientation/Men	nory/Cognitive Function:					
	Judgment and m	emory are not always					
	good. Needs mo	onitoring and guidance					
	and occasional re	edirection Current and					
	past behavioral i	ssues: Emotional states					
	-	unusual demand on					
	others"						
	A "Nurse's Note:	s" dated 9/30/11 at 5:15					
	P.M., included, b	out was not limited to,					
	"New resident ac						
	No documentation	on was located in					
	Resident #B's cli	inical record regarding					
		lmission to the facility's					
	locked dementia	-					
	On 6/18/12 at 3:0	00 P.M., Resident #B's					
		e locked unit was					
		he director of Nursing					
	[DoN].						
	[ [ ~ ~ ~ . ].						

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 37 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
			B. WIN	G		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIEF		_	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SULLEE				N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 6/21/12 at 11						
	interview, the De	oN indicated the facility					
	did not have an i	individual evaluation					
	completed by the	e facility for Resident					
	#B's admission t	o the locked unit.					
	4. During initial tour of the facility's						
	locked dementia	unit, L.P.N. #1 identified					
	Resident #C as non-interviewable						
	requiring assistance with activities of daily living and a history of falls without						
	injury.						
	On 6/20/12 at 6:	05 A.M., Resident #C's					
		wed. diagnoses included,					
		ited to, hypertension,					
		ia, and cerebral vascular					
		et sided hemiplegia.					
	decident with ici	t sided heimpiegia.					
	Resident #C was	s admitted to the facility's					
		n 1/16/12 and then					
	_	e facility's locked					
	dementia unit on	•					
	dementia unit on	12/13/12.					
	Δ "Pre-Admissio	on Assessment and Care					
	Plan for Indiana						
		12/21/11, no time,					
		· · · · · · · · · · · · · · · · · · ·					
	· ·	s not limited to, "Fall					
	Risk: Services I						
	wheelchair prim	•					
	^	ole to ambulate with					
	_	ndent with ambulation					
	Requires escort t	to most daily meals,					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 38 of 70

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		06/21/2012
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF F	PROVIDER OR SUPPLIER			N MICHIGAN RD	
	AT TUDOR GARD	ENS LLC		VILLE, IN 46077	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		tings High [fall risk]			
		esident #C] Independent			
		Requires occasional			
	assistance and or	cueing [with			
	transfers]"				
	A "Nursing Prog	ress Notes" dated			
	2/15/12 at 2:00 F	P.M., included, but was			
		Resident [#C] transferred			
		ke Secure Village], the			
	facility's locked	<b>O</b> 2.			
	idenity 5 locked	dementia dint			
	There was no do	cumentation of an			
		ssessment and Care Plan			
		sted Living Facilities" for			
		15/12 to the locked			
	dementia unit.				
	On 6/20/12 at 11	:30 A.M., the evaluation			
		rice plan or assessment			
		s transfer to the locked			
		as requested from the			
	DoN.	is requested from the			
	DON.				
	On 6/21/12 at 11	:30 A M in an			
		oN indicated the facility			
		ndividual evaluation			
		e facility for Resident			
	#C's admission to	o the locked unit.			
	5 On 6/18/12 at	3:00 P.M., the facility			
		for the assisted living			
		•			
		ecured Village [KSV]			
	Llocked dementia	a unit] was received from			

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 39 of 70

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 06/21/2012		
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE  11755 N MICHIGAN RD ZIONSVILLE, IN 46077				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) the Executive director.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODECTION OF THE APPRODES OF THE APPROPRIES OF THE APP	D BE COMPI		
	The "Residency Requirements for Keepsake Village" dated 6/12, included, but was not limited to, "Policy Statement: The prospective resident or residents: must have a diagnosis of dementia, Alzheimer's or other cognitive impairment An intake interview prior to admission will be performed to determine KSV eligibility to include, but not limited to, physician's history and physical, interview with family and resident, a nursing assessment to included decreased judgment, behaviors, wandering tendencies, medication regime and mini-mental exam"  This State Residential tag refers to Complaint IN00109927.					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 40 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
			B. WING		06/21/2012
	ROVIDER OR SUPPLIER		11755	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD VILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R0217	facility, using appressives to be president shall be (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services and revised as a the resident and change. Either the request a service (3) The agreed usigned and dated of the service playersident upon reference (4) No identificat services provided subsequent to the no need for a change of the services provided subsequent to the no need for a change of the services provided subsequent to the no need for a change of the services provided subsequent to the no need for a change of the services provided subsequent to the no need for a change of the services provided subsequent to the no need for a change of the services provided subsequent to the no need for a change of the services provided subsequent to the noneed for a change of the services provided subsequent to the noneed for a change of the services provided subsequent to the noneed for a change of the services provided subsequent to the noneed for a change of the services provided subsequent to the noneed for a change of the services provided subsequent to the noneed for a change of the services provided subsequent to the noneed for a change of the services provided subsequent to the noneed for a change of the services provided subsequent to the noneed for a change of the services provided subsequent to the none of the se	ciency inpletion of an evaluation, the propriately trained staff dentify and document the ovided by the facility, as  offered to the individual appropriate to the:  offered shall be reviewed ppropriate and discussed by facility as needs or desires are facility or the resident may be plan review.  pon service plan shall be do by the resident, and a copy an shall be given to the quest.  It ion and documentation of the individual appropriate and documentation of the initial evaluation indicate ange in services.  In on of medications or the dential nursing services, or a licensed nurse shall be fication and documentation			
	facility failed to the services prov to 2 of 9 resident and history of fall #E]; and failed to the resident's leg	review and interview, the identify and document ided for fall prevention, s identified with current ls [Residents #B and o ensure the resident or al representative signed Service Plan for 2 of 10	R0217	1. A chart audit was performe ensure proper signatures on the most current service plans. Correct signatures will be attained by 7/9/12. 2. A chart audit was performed to ensure proper signatures on the most current service plans. Correct signatures will be attained by 7/9/12. 3. Reviewed policy ar	ne G

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 41 of 70

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
			B. WING		06/21/2012		
NAME OF I	DDOMDED OF GIRDI ICI	,	STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF			N MICHIGAN RD			
HEARTH	AT TUDOR GARD	ENS LLC	ZIONS	VILLE, IN 46077			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	-	ents #D and #B] reviewed		procedures with admissions st to ensure service plans will be			
		signatures; in a sample of		properly signed before admiss			
	10 residents revi	ewed.		Reviewed with director of nurs			
				the policy and procedure for			
	Findings include			quarterly and significant chang of condition updates to be	jes		
				properly signed on the residen	t I		
		t 12:55 P.M., Resident		service plan. 4. The director			
		reviewed. Diagnoses		nursing will monitor all service			
	-	re not limited to,		plans to ensure proper signatulare present and timely. This w			
	dementia and ce	Ilulitis of the left leg.		be reviewed during the quarter			
				QA meeting ongoing.	,		
		admitted to the facility					
	1	cked dementia unit on					
	9/30/11.						
		on Assessment and Care					
	Plan for Indiana	•					
		9/29/11, no time,					
	included, but wa	· ·					
		ulates independently,					
	1	ndently Social Service:					
		nory/Cognitive Function:					
	_	emory are not always					
	~	onitoring and guidance					
		edirection Current and					
	^	ssues: Emotional states					
		unusual demand on					
	others"						
	1	sessment and Care Plan					
		sted Living Facilities"					
		time, included, but was					
		Mobility: Resident					
	ambulates indep	endently Transferring:					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 42 of 70

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	OING	00	COMPL	ETED
			B. WING			06/21/	2012
		1		_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	3	1		N MICHIGAN RD		
HEARTH	AT TUDOR GARD	DENS LLC			/ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·		P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident indeper	ndent with transfers"					
	No other "Asses	sment and Care Plan for					
	Indiana Assisted	Living Facilities" after					
		ated in Resident #B's					
	clinical record.	The state of the s					
	cimical iccord.						
	A !!NI	rmaga Natasii data 1 5/5/12					
		gress Notes" dated 5/5/12					
	· ·	cluded, but was not					
	· ·	dent observed on floor in					
		on buttocks Action					
	taken: Resident	alert to self able to move					
	on unit freely	Outcome: Family and					
	M.D. notified"						
	A "Nursing Prog	gress Notes" dated					
		A.M., included, but was					
	· ·	Resident observed on					
	floor tripped o						
		tion taken: M.D.					
	notified, open ar	rea noted on left eye					
	Outcome: Fami	ly/M.D. notified"					
	A "Nursing Prog	gress Notes" dated					
		P.M., included, but was					
		Resident noted tripping					
	· ·	ction taken: M.D. made					
		t and sent to emergency					
		and sent to emergency					
	room"						
	A "Nursing Proc	gress Notes" dated					
		P.M., included, but was					
		Resident's wife request					
	resident to be se	nt to the emergency room					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 43 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILD	ING	00	06/21/	
			B. WING			00/21/	2012
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
HEARTH	I AT TUDOR GARD	ENS LLC			I MICHIGAN RD ILLE, IN 46077		
(X4) ID	•	TATEMENT OF DEFICIENCIES		ID	,		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PF	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	related to fall on	5/16/12 states resident					
		of dizziness and head					
	1 *	was sent to emergency					
	^	and sent back with					
	diagnosis of contusion"						
	A "Nursing Prog	gress Notes" dated					
	"	, included but was not					
	·	dent returned from					
	hospital noted						
	transferring and	•					
		C					
	A "Nursing Prog	gress Notes" dated					
		P.M., included, but was					
		Fall without injury"					
	ĺ	3 3					
	On 6/18/12 at 3:	00 P.M., documentation					
	of the fall prever	ntion services provided to					
	_	requested from the DoN.					
	On 6/19/12 at 9:	00 A.M., the DoN					
	provided a "Qua	rterly Assessment and					
	Care Plan For In	diana Assisted Living					
	Facilities" dated	6/15/12.					
	The assessment	included, but was not					
	limited to, "Mob	ility: Resident currently					
	using wheelchair	r for ambulation due to					
	resident has had	a decline in ambulating					
	Transferring: Re	esident requires					
	assistance with t	ransfers"					
		45 P.M., the DoN					
	indicated the fac	ility did not have any					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 44 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE : COMPL	ETED	
			B. WIN			06/21/	2012
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>		DDRESS, CITY, STATE, ZIP CODE  N MICHIGAN RD	•	
HEARTH	AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	documentation of falls prior to 6/15	f services offered for 5/12.					
		admitted to the facility cked dementia unit on					
	Plan for Indiana	9/29/11, no time, did not for					
	the DoN indicate have other docur signature on it fo	or the "Pre-Admission Care Plan for Indiana					
	dementia unit, in #1, Resident #D non-interviewabl behaviors and re- geriatric psychia	obile with her walker,					
	record was revie included, but we	re not limited to, chavioral disturbances					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 45 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			06/21/	2012
NAME OF I	DROVIDED OD GUDDU IEE		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		11755	N MICHIGAN RD		
HEARTH	AT TUDOR GARD	DENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		on Assessment and Care					
	Plan for Indiana	•					
		2/8/12, no time, did not					
	include a signatu						
	"Resident/Respo	onsible Party."					
	On 6/19/12 at 9:00 A.M., in an interview,						
		ed the facility did not					
	have other documentation with a						
	signature on it for the "Pre-Admission						
		Care Plan for Indiana					
	Assisted Living	Facilities."					
		ecord for Resident #E					
	was reviewed on	1 6/18/12 at 1:30 P.M.					
	Diagnoses include	ded, but were not limited					
	to, degenerative	joint disease,					
	hyperlipidemia [	high cholesterol disease],					
	senile dementia-	-Alzheimer's type, and					
	multi-nodular go	oiter. On $6/5/12$ , she was					
	admitted to an ac	cute care hospital					
		in the facility. Diagnoses					
		ided right parietal					
		ma, left inferior orbital					
		ow out" fracture with					
		e maxillary sinus, a left					
	_	, and left knee abrasion.					
		, with fort fires dordston.					
	A "Home Discha	arge Instructions" form					
		nursing home, dated May,					
		the resident was a fall					
		d and chair alarms, and					
	11511, 10441104 00	viiaii aiaiiiio, aiia					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 46 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL		
			A. BUILDING B. WING		06/21/	
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD	Е	
				N MICHIGAN RD		
	I AT TUDOR GARD			/ILLE, IN 46077		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)		DATE
	had received the	<u> </u>				
		<b>F</b>				
	A "Nursing Prog	gress Notes" entry, dated				
	5/31/12 at 10:00	A.M. The note indicated				
	"Post fallResid	lent ambulating in main				
	dining room and	I fell. C.N.A. stated that				
		pting to get to resident to				
		lation. Staff re-educated				
	_	dent to ambulate.				
		tly on antibiotic for				
	urinary tract infe	ection, sinus infection."				
	Subsequent note	es were dated: 6/4/12 at				
	_	ost fallResident observed				
	1	ment after investigation				
	_	12 at 10:00 A.M"Post				
	-	as admitted to hospital				
	related to fall 6/3	•				
		.,				
	A 90-day "Asses	ssment and Care Plan For				
	Indiana Assisted	Living Facilities" form,				
	dated 2/24/12, h	ad an entry addressing				
	"Mobility," and	indicated the following:				
		vices Provided: Resident				
		ing restorative services.				
		nce with ambulation.				
	_	public area when awake				
		vill ambulate unassisted.				
		tory of falls. Resident				
	_	aff when resident abulate independently.				
		heelchair at times.				
		to most daily meals,				
	requires escoit	io most dany meats,	1			

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 47 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		OO	(X3) DATE S COMPL		
			B. WING			06/21/	2012
	PROVIDER OR SUPPLIER		1	11755 N	DDRESS, CITY, STATE, ZIP CODE I MICHIGAN RD LLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	activities and out	tings."					
	Care Plan," dated information that  Other services to resident with a h unassisted ambur Service Plan followed	-day "Assessment and d 5/13/12, listed the same was on the 2/24/12 plan.  be provided to this istory of falls and lation, or an updated owing the falls in May we services, were not					
	11:50 A.M., the given the opports additional evider specific services providing, or plathis resident who	nned on providing, to had a history and 2 f which resulted in					
	President of Ope interim Administ annual survey, in issue had been cl	t that time, the Vice rations, who had been the trator during the last adicated she thought this leared up from the indings of the same					
	no additional do	on 6/21/12 at 3:00 P.M., cumentation of a service the resident's falls was					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 48 of 70

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	COMPLETED 06/21/2012		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
HEARTH	AT TUDOR GARDI	ENS LLC	ZIONS\	N MICHIGAN RD /ILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	provided for revi	ew.			
		ential tag relates to			

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 49 of 70

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
			B. WIN			06/21/	2012
NAME OF P	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC		ZIONS\	/ILLE, IN 46077		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
R0273	410 IAC 16.2-5-5	<u> </u>		1710			BATE
	Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are						
		ordance with state and local					
	sanitation and safe food handling standards,						
	including 410 IA0	C 7-24.					
		ation, interview, and	R02	273	The items in question were		06/21/2012
	record review, the facility failed to label food to indicate the date it was made or a use-by date, the facility failed to ensure a flour scoop was not stored inside the flour bin, and the facility failed to ensure				discarded or corrected immediately on 6/18/12. Kitchen staff members were in-serviced		
					on proper sanitation and safe		
					food handling standards. 2. A cleaning checklist is being utilized		
					with staff signatures to ensure	ires to ensure	
		ced proper glove use and			proper food sanitation is being		
	_	the kitchen. These es had the potential to			completed. 3. A safe food handling standards in-service will		
	_	residents who ate meals			be conducted on 7/09/12	VVIII	
	from the kitchen.				reiterating the training for hand		
	from the kitchen.				washing and glove usage in the kitchen. (See Attachment F)		
	Findings include	:			The food service director will	+.	
	1. During the ini	itial observation of the			monitor the kitchen cleaning checklist. It will be reviewed a	t	
	kitchen on 6-18-	12 at 10:15 a.m., a tray in			the quarterly QA		
	the reach-in refri	gerator was observed to			meeting ongoing.		
	contain 7 sealed	fruit cups and two					
	pitchers containing	ng a dark liquid. One					
	pitcher was full;	the other was ¾ full.					
	Another full pitch	her was observed to					
	contain a yellow	liquid. These items did					
	_	s. Also observed in the					
	refrigerator was a	an 8-quart clear plastic					
	_	lid that contained 4					
		ble. This item contained					
		late, "6-8-12." Also					
	a label with the t	iaic, 0-0-12. Also					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 50 of 70

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WINC			06/21/	ZU1Z
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	ENS LLC			/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)	]	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		refrigerator was a		ing			DATE
		bottle containing green					
	tea. The seal was broken, and the bottle						
	was less than full.						
	During an interview at this same time, the						
	Director of Food Services indicated the						
	pitchers contained juice and lemonade,						
	and that the 20-oz green tea belonged to a						
	staff member.						
	2. On the counter next to the food						
	preparation table and under the toaster						
	were observed a	clear plastic bag					
	containing a loaf	f of Texas toast, a clear					
	plastic bag conta	ining two pieces of rye					
	bread, a clear pla	astic bag containing a loaf					
	of wheat bread, a	a clear plastic bag					
	containing one-q	uarter loaf of wheat					
	bread, a clear pla	astic bag containing					
	one-half loaf of	white bread, and a clear					
	plastic bag conta	ining four dinner rolls.					
	These items did	not contain labels and					
	were not marked	with a use-by date.					
	During an interv	iew at this same time, the					
	Director of Food	Services indicated he					
	utilizes a first-in	, first-out method of					
	rotating food iter	ms.					
	3. In the walk-ir	n freezer was observed an					
	8-quart plastic co	ontainer containing a					
	white, curd-like	food item. This item did					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 51 of 70

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	ĺ	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED
			B. WING			1/2012
NAME OF I	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CO	ODE	
HEARTH	AT TUDOR GARD	ENS LLC		55 N MICHIGAN RD NSVILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	not contain a lab					
	1	iew at this same time, the				
Director of Food Services indicated the						
	item was gorgonzola cheese.					
	4. In the dry storage area were observed a					
l	stack of trays containing clear plastic bags					
	of bread items.	The top tray contained				
	Texas toast; one	full loaf and one				
	half-loaf. The se	econd tray contained				
	unopened loaves	of raisin bread. The				
	third tray contain	ned three unopened				
	loaves of rye bre	ad. The fourth tray				
	contained four u	nopened packages of				
		ese items did not contain				
	labels and were i	not marked with a use-by				
	date.	Ž				
	During an interv	iew at this same time, the				
	1	Services indicated he				
		h the bread delivery				
	_	labeling of these items				
	in the future.	, labeling of these items				
	5. Also in the dr	ny storaga araa a				
		l " flour " was observed				
	_	scoop was inside the				
	container.	die de etce				
		the dry storage area were				
	1	art plastic container				
l		rts of rice, a 6-quart				
l	plastic container	containing two quarts of				

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 52 of 70

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE : COMPL	
			A. BUII B. WIN	LDING G		06/21/	2012
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					N MICHIGAN RD		
	AT TUDOR GARD				/ILLE, IN 46077		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	crisped rice cerea	al, and a 6-quart plastic					
	container contain	ning five quarts of bran					
	flakes cereal. Ar	nother shelf contained a					
	12-ounce package of strawberry glaze that						
	had been opened and wrapped in plastic						
	wrap. These items did not contain labels.						
	7. At 11:30 a.m.	, Dietary Staff #6 was					
	observed with gle	oved hands to move from					
	the food preparation area to the dry						
	storage area. He was observed to retrieve						
	a loaf of bread ar	nd return to the food					
	preparation area,	and then to open the					
	bread bag and rea	move slices of bread. He					
	was then observe	ed to dish food into					
	containers using	a ladle. At no time					
	during this obser	vation did Dietary Staff					
	#6 remove his gl	oves or wash his hands.					
	During an intervi	iew at 12:52 p.m., the					
	Director of Food	Services indicated he					
	-	a representative from the					
	bread company v	vho had indicated he					
	could provide co	lor-coded twist ties to					
	help keep track o	of food expiration dates					
	by week.						
	During the daily	conference at 2:54 p.m.,					
		es of the facility's food					
	labeling, glove u	se, and hand washing					
	policies were req	uested.					
	On 6-19-12, at 9:	:15 a.m., the Executive					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 53 of 70

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE ( COMPL	
THEFTERN	or condition	IDENTIFICATION NOMBER.		LDING		06/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC		ZIONSV	/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		d copies of documents		1110			DITTE
	_	fety, " "Storage of					
	Food in Refrigeration, " and " Glove Use						
		loyees, " all with an					
	_	9-27-2011. The "Food					
		was reviewed at that time,					
	' '	t was not limited to, the					
	following information:						
	" All staff will be aware of proper food						
	handling and storage procedures. " " All						
	staff will be aware of proper handling of						
	dirty and clean u	tensils." "Food will be					
	served in such a	way as to prevent growth					
	of bacteria. "	All food service staff					
	will wash their h	ands upon entering the					
	kitchen and when	n moving from one food					
	prep area to anot	her. "					
	The document tit	tled, "Storage of Food in					
	Refrigeration " v	was reviewed at 9:17 a.m.					
	This document in	ncluded, but was not					
	limited to, the fo	llowing information:					
	" Food being ret	urned to storage after					
	cooking or prepa	ration must be covered. "					
	" All containers i	must be labeled with the					
	contents and date	e food item was placed in					
	storage. " " Pre	eviously cooked foods can					
	be held in refrige	eration of 41 degrees F or					
	lower for up to 3	days and then must be					
	discarded. " ".	employee food items					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 54 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  OO COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	00		
			B. WING			06/21/	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE  N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC			ILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	)	DROWING DLANLOS CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re l	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
		d in any refrigerator or					
	freezer in the ma						
	The document titled, "Glove Use for						
	Dietary Employees " was reviewed at						
	9:19 a.m. This document included, but						
	was not limited t						
	information:						
	" Gloves must b						
	handling food in						
	need to be chang						
	become soiled, b	efore beginning a new					
	task, at least ever	ry 4 hours during					
	continual use, an	d after handling raw					
		handling cooked or					
	ready-to-eat food	•					
	"Retail Food Esta	ablishment Sanitation					
	Requirements Ti	tle 410 IAC 724"					
	effective 11-13-0	04 indicates the					
	following:						
	# GEG 130 ( ) T	2 1 1 . 11					
	` ′	Food employees shall					
		s (7) during food ften as necessary to					
		contamination and to					
		ntamination when					
	changing tasks						
	` ′	Food employees shall					
		as specified under					
		is rulefood employees					
	shall not contact	exposed, ready-to-eat					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 55 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMPI <b>06/21</b>	LETED	
	PROVIDER OR SUPPLIER		11755	ADDRESS, CITY, STATE, ZIP COI N MICHIGAN RD /ILLE, IN 46077	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	washed as specification of this rule as utensils, such as tissue. (2) Spatul Single-use glove "SEC 191. (a) Expotentially hazar held in a retail for more than twenty clearly marked to by which the foother premises, solone (1) of the tercombinations specified in section 191(a) or be discarded if it the temperature as specified in section as container and arked with a datemperature and	that have not been fied in sections 129 and and shall use suitable the following: (1) Deli as. (3) Tongs. (4) s "  Accept as specified in efrigerated, ready-to-eat, dous food prepared and rod establishment for cy-four (24) hours shall be to indicate the date or day d shall be consumed on d, or discarded, based on imperature and time ecified as follows and the fon shall be counted as day  A food specified in 191(b) of this rule shall: (1) exceeds either of and time combinations on 191(a) of this rule, the product is frozen; (2) for package that does not ty; or (3) is appropriately attended to the following the or day that exceeds a time combination as on 191(a) of this rule. "				

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 56 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  06/21/2012	
	ROVIDER OR SUPPLIER  AT TUDOR GARD  SUMMARY S		11755	F ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD SVILLE, IN 46077  PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE
R0298	(2) A consultant employed, or und (A) be responsibin 856 IAC 1-7; (B) review the drivation of the following procedures of or administering, are as medication re (D) report, in writh his or her design dispensing or ad (E) review the drivation receiving these sixty (60) days.  Based on observation of the factorsultant Pharm [Emergency Druito ensure the ED deficient practice EDK's of the factor affect 1 of 27 dementia unit and non-locked unit.  Findings include On 6/18/12 at 10 locked dementia	Services - Deficiency pharmacist shall be der contract, and shall: le for the duties as specified ug handling and storage acility; ultation on methods and dering, storing, and disposing of drugs as well cord keeping; ting, to the administrator or ee any irregularities in ministration of drugs; and ug regimen of each resident services at least once every ation, record review, and cility failed to ensure the nacist monitored the EDK g Kit] monthly and failed K was not expired. The eaffected 2 of 2 insulin ility and had the potential residents on the locked d 4 of 81 residents on the services in time, L.P.N. #1 ent as an insulin	R0298	1. Immediately all expired medications in the EDK were destroyed or replaced with current medications. Our pharmacy consultant will ensicompliance of the EDK expiradates on a monthly basis ongoing. 2. All EDK items with checked for currency. 3. Pharmacy consultant and director of nursing will be checking the EDK monthly to ensure no expired medication on premises. 4. Pharmacy consultant and director of nur will be checking the EDK morto ensure no expired medication to ensure no expired medication on premises.	ere  n is sing nthly

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 57 of 70

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION  00	СО	ATE SURVEY MPLETED /21/2012
			B. WING			/Z 1/ZU  Z
NAME OF I	PROVIDER OR SUPPLIEF		STRI	EET ADDRESS, CITY, STATE,	ZIP CODE	
TWINE OF I	NO VIDER OR SOTT EIE	•		55 N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC	ZIO	NSVILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF COPPECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFI		TION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		NCY)	DATE
	On 6/18/12 at 1:	00 P.M., the Director of				
	Nurses provided	a list of residents in the				
	facility who required special needs. Four					
	residents in the r	non-locked part of the				
	facility were idea	-				
	insulin-dependent diabetics, requiring the					
	use of insulin.	in the color, requiring the				
	On 6/20/12 at 9:00 A.M., environmental tour was initiated with the Executive Director, the Environmental Services					
	1					
	Director, and the	Housekeeping				
	Supervisor.					
	0 (/20/12 -4.0.	45 A.M. 1 ive 1iv FDV				
		45 A.M., 1 insulin EDK,				
		cked dementia unit				
		an expiration date of				
		K included the following				
		og, Novolin 70/30,				
	Novolin R, Novo	olin N, and Humalog				
	75/25.					
	On 6/20/12 at 9:	55 A.M., 1 insulin EDK,				
	located in the ass	sisted living medication				
	refrigerator, had	an expiration date of				
	7/2011. The ED	K included the following				
	insulin's: Novol	og, Novolin 70/30,				
		olin N, Humalog Mix				
	75/25, and Lantu	•				
	On 6/20 12 at 10	30 A.M., the Executive				
		d a policy and procedure,				
	"Facility and Pha					
		iration dated 9/27/11.				
	I Montoning LAP	1 and 1 and 1 / 2 / / 1 1 .		1		

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 58 of 70

AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/21/2012	
	PROVIDER OR SUPPLIER		11755	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD /ILLE, IN 46077	3
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	was not limited to consultant Pharm EDK monthly are on expiration date.  On 6/20/12 at 12 Director and Dolo of the consultant 5/2/12. They incomplete the pharmacist visits between units. The consultant is the consultant of the consultant structure of the consultant structure.	procedure included, but o, "Procedure: The macist will monitor the ad will ensure compliance res"  1:00 P.M., the Executive N indicated the last visit Pharmacist was on dicated the consultant is monthly and alternates They were unsure of what int Pharmacist reviewed			

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 59 of 70

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	LDING	00	COMPL	ETED
			B. WIN			06/21/	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC			/ILLE, IN 46077		
					1122, 114 40077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0301	410 IAC 16.2-5-6	( )( )					
	Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following:						
	(A) Resident 's f	•					
	(B) Physician 's name.						
	(C) Prescription number.						
	(D) Name and strength of the drug.						
	(E) Directions for						
		and expiration date (when					
	applicable).	ddress of the pharmacy that					
	<ul><li>(G) Name and address of the pharmacy that filled the prescription.</li><li>If medication is packaged in a unit dose,</li></ul>						
		tions that comply with the					
	acceptable pharr	maceutical procedures are					
	permitted.						
	Based on observa	ation and interview, the	R03	01	1. On 6/20/12 the lantus insul		06/21/2012
	facility failed to	ensure proper labeling of			pen and the bottle of apisol was labeled correctly.2. All medications were reviewed for		
	medications loca	ted in the medication					
	refrigerator. The	e deficient practice			proper labels and dates. This		
	impacted 2 of 2 f	facility medication			review was completed on or		
	refrigerators and	had the potential to			before 7/9/12.3. During month	•	
	affect 1 of 27 and	d residents residing on			review by our pharmacy, dates and labels will be checked for	5	
	the locked demen	ntia unit, and 81 of 81			compliance. All nurses will		
		n the assisted living part			monitor their assigned carts by	y	
	of the facility.				shift for date and label		
					appropriateness. 4. The direc	tor	
	Findings include				of nursing will review random		
	i manigs merade	•			samples of medications month to ensure compliance of prope		
	On 6/18/12 at 10	·30 A M tour of the			dates and labels. This will be	.1	
	On 6/18/12 at 10:30 A.M., tour of the locked dementia unit was initiated with L.P.N. #1. At that time, 1 resident was identified as a insulin dependent diabetic.  On 6/20/12 at 9:00 A.M., environmental				reviewed at the quarterly QA		
					meeting ongoing.		
	tour was initiated	d with the Executive					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 60 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		B. WING		06/21/2012	
				ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	₹		55 N MICHIGAN RD	
	AT TUDOR GARD			NSVILLE, IN 46077	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	•	ICY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPRO	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Director, the En	vironmental Services			
	Director, and the	e Housekeeping			
	Supervisor.				
	1				
	On 6/20/12 at 9.	40 A.M., a new Lantus			
		located in the locked			
		edication refrigerator			
		nt label. The Lantus			
	Insulin Pen had	not been used.			
		50 A.M., an open bottle			
	of Apisol Injecti	on [Tubersol], was			
	located in the as	sisted living medication			
		out an open or use by			
	date.				
	date.				
	On 6/20/12 at 10	0.00 A M in an			
		oN indicated she was			
		d for labeling all			
		n resident information and			
	open dates.				
			I	<u> </u>	I

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 61 of 70

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY	
AND PLAN OF CORRECTION ID:		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
			B. WINC			06/21/	2012
			B. WINC	_	DDDESS CITY STATE ZID CODE		
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIEADTU		ENC II C			N MICHIGAN RD /ILLE, IN 46077		
ПЕАКІП	AT TUDOR GARD	ENS LLC		ZIONSV	71LLE, IN 40077		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0306	(g) Medications a shall be disposed appropriate fede disposition of any destroyed medic the resident's conclude the follow (1) The name of (2) The name and (3) The prescript (4) The reason for (5) The amount of (5) The amount of (6) The method of (7) The date of the disposal of the dis	Services - Noncompliance administered by the facility d in compliance with ral, state, and local laws, and y released, returned, or ation shall be documented in linical record and shall ving information: the resident. d strength of the drug. ion number. or disposal. disposed of. of disposition. ne disposal. e of the person conducting ne drug. e of a witness, if any, to the rug. review, observation, and cility failed to ensure the of an expired medication refrigerators and failed to of medications no longer ident in 1 of 1 resident dication errors in a idents reviewed.	R030	06	1. All expired or D/C medication were destroyed immediately of 6/20/12. 2. Reviewed destroy medication logs to ensure time response to discontinued or expired medication. 3. Review policy and procedures for destruction of medications. 4. Director of nursing will monito changes and expiration dates medications and destroy them timely. This will be reviewed in the quarterly QA meeting ongoing.	n ved ely w of r of	07/09/2012

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 62 of 70

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	LTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
		A. BUIL			06/21/		
			B. WINC	_	DDDEGG GITW GTATE TID GODE	00/21/	20.2
NAME OF I	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE  N MICHIGAN RD		
HEARTH	I AT TUDOR GARD	ENS LLC			ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	On 6/20/12 at 9::	55 A.M., an open bottle					
	of "Mary's Mout	hwash" with an					
	expiration date of	of 4/7/12 was located in					
	the assisted livin	g refrigerator.					
	2 0 0 (/19/12	10.20 AM J					
		t 10:30 A.M., during					
		e locked dementia unit, in					
		h L.P.N. #1, Resident #D s non-interviewable, with					
	a history of beha	·					
	admission to the geriatric psychiatric facility, independently mobile with her						
	walker, and a his	•					
	warker, and a me	story or runs.					
	On 6/18/12 at 1:4	45 P.M., Resident #D's					
	record was revie						
	included, but we	re not limited to,					
	dementia with be	ehavioral disturbances					
	and hypothyroid	ism.					
	A !!NI	wasa Natasiidata 1 5/21/12					
		gress Notes"dated 5/21/12 eluded, but was not					
	· ·	dent given Xanax 0.5					
	•	order for medication					
	_	medication given					
	without order f	C					
	without order	diffing aware					
	On 6/21/12 at 11	:30 A.M., the DoN					
	indicated Reside	nt #D had a previous					
		prior to her re-admission					
	to the facility on	3/16/12. She indicated					
	•	nax was left in the					
	medication cart.	The DoN indicated it					
	was policy to des	stroy medication not					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 63 of 70

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
			B. WING		06/21/2012		
NAME OF P	PROVIDER OR SUPPLIE	<b>.</b> R	STREET .	ADDRESS, CITY, STATE, ZIP CODE	•		
				N MICHIGAN RD			
HEARTH	AT TUDOR GARD	DENS LLC	ZIONS	VILLE, IN 46077			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFECTIVE 1)	DATE		
	re-ordered.						
	On 6/21/12 at 3:	45 P.M., the DoN					
		trolled Drug Use Record"					
	_	and the Xanax. The					
		but was not limited to, "6					
		on 6/19/12" with 2					
	signatures to wit						
	Signatures to wit	meda disposar.					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 64 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
			A. BUIL B. WINC			06/21/	2012
NAME OF PROVIDER OR SUPPLIER HEARTH AT TUDOR GARDENS LLC				STREET A	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
R0349	(a) The facility mon each resident maintained under employee of the responsibility. The follows: (1) Complete. (2) Accurately do. (3) Readily access (4) Systematicall Based on intervioral facility failed to pressure measure clinical record, for had a physician's pressure measure residents reviewed.  Findings include  The clinical record reviewed on 6/18 Diagnoses include to, senile dement agitation, lower of multi-nodule goi [high cholesterole the dated, for "Monitor agitation] sentences and the dated, for "Monitor agitation] sentences and the dated, for "Monitor agitation and the dated agitation agitatio	- Noncompliance ust maintain clinical records . These records must be r the supervision of an facility designated with that he records must be as  cumented. ssible. y organized. ew and record review, the ensure a weekly blood ement was recorded in the for 1 of 1 resident who corder for a weekly blood ement; in a sample of 10 ed. [Resident #E]  ;  rd for Resident #E was 8/12 at 1:30 P.M. led, but were not limited hiaAlzheimer's type with extremity edema, ter, and hyperlipidemia disease].  ohysician order recap heet listed an order, not tor blood pressure less everytolic blood pressure less	R034	49	1. Physician was called to cla the order for BP monitoring. Nursing staff will follow Physic orders obtained. 2. Random audit of clinical records for 11 of 108 residents by the directonursing ensuring that Physicia orders are being followed. 3. Nursing staff in-serviced on following Physician orders on 7/9/12. 4. Review of clinical records randomly on a monthly basis by the director of nursing Review of those findings in the quarterly QA meeting ongoing	cian  out r of n  y g. e	07/09/2012

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 65 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
			B. WING		06/21/2012	
NAME OF T	DROWNER OR GURRI TO			ET ADDRESS, CITY, STATE, ZIP CODE	E	
NAME OF F	PROVIDER OR SUPPLIER		1175	5 N MICHIGAN RD		
	AT TUDOR GARD			ISVILLE, IN 46077	<u> </u>	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL		
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		
TAG		· · · · · · · · · · · · · · · · · · ·	TAG	DEFICIENCE ()	DATE	
		2 Treatment Record listed				
	the order, but no	*				
		ere documented on the				
	form.					
	The April 2012	Treatment Record also				
	• •	out no blood pressure				
	Í	ere documented on the				
		ere documented on the				
	form.					
	The May 2012 7	Treatment Record listed				
	l • •	ood pressures were				
		•				
		5/2, 5/9, 5/16, 5/23, and				
	5/30/12.					
	Δ "Vital Sign Flo	ow Sheet" had monthly				
		documented on 2/3/12,				
	•	·				
	3/2/12, 4/1/12, 3/	/1/12, and 6/1/12.				
	During the daily	conference on 6/19/12 at				
		irector of Nursing was				
		unity to submit any				
	1	nce/documentation that				
		l pressure measurement				
	had been taken a	*				
	naa ooon taken a	10001uou.				
	In an interview o	on 6/21/12 at 11:45 A.M.,				
		Jursing indicated she was				
		y other documentation				
		ekly blood pressure				
		lid not know if the				
		ere actually done; and, if				
		easurements were not				
		casarements were not				
	recorded.					

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 66 of 70

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2012 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		06/21/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	R		N MICHIGAN RD	
HEADTH	AT TUDOR GARD	ENSTIC		/ILLE, IN 46077	
				71LLL, IN 40077	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 67 of 70

STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		B. WIN			06/21/	2012	
			B. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				N MICHIGAN RD		
HEARTH	AT TUDOR GARD	ENS LLC			VILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0352	410 IAC 16.2-5-8 Clinical Records (e) The clinical refollowing: (1) Sufficient inforesident. (2) A record of the (3) Services prove (4) Progress notes for between December 31,2012; for 1 or history of chronical and was a fall rist at least recent 2 for residents reviewed.  Findings include  The clinical record reviewed on 6/18 Diagnoses include to, degenerative thyperlipidemia [1] senile demential multi-nodular go admitted to an action of the clinical record and the clinical record reviewed on 6/18 and the clinical record reviewed on 6/18 big and the clin	3.1(e)(1-4) - Noncompliance ecord must contain the formation to identify the ne resident 's evaluations. vided. es. ew and record review, the maintain nursing or a 5 month period oer 30, 2011 and May of 1 resident who had a c aggressive behaviors, ok who had experienced falls, in a sample of 10 ed. [Resident #E] : rd for Resident #E was 8/12 at 1:30 P.M. ded, but were not limited joint disease, high cholesterol disease], -Alzheimer's type, and iter. On 6/5/12, she was	R03		1. N/A2. Random audit of clin records for 11 out of 108 residents by the director of nursing ensuring that proper nurse charting is in place. 3. Nursing staff in-serviced on policy and procedure for proper resident documentation on 7/9/12. 4. Review of clinical records randomly on a monthl basis by the director of nursing Review of those findings in th quarterly QA meeting ongoing	er y g. e	07/09/2012

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 68 of 70

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO  A. BUILDING	NSTRUCTION 00	(X3) DATE S COMPLI 06/21/3	ETED	
	PROVIDER OR SUPPLIEF		11755	ADDRESS, CITY, STATE, ZIP CODE N MICHIGAN RD /ILLE, IN 46077		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	from a certified of 2011, indicated to 18DH indicated displayed behaving pulling hair of 3 8/17/12, 9/10/11 physician's program indicated "Asked staff's reports of is quite confused Often approach I One "Nursing Profound in the clim 12/30/11. The mass dated 5/31/1 note indicated "Fambulating in m C.N.A. stated the get to resident to Staff re-educated ambulate. Resident infection."  Subsequent note 10:00 A.M., "Po on floor in aparts of fall; and 6/6/1.	arge Instructions" form nursing home, dated May, the resident was a fall d and chair alarms, and rapies. Incidents reported to the resident had fors of striking and other residents on and 9/24/11. A ress note, dated 12/20/11, if to see patient with increased behaviors. She land, slapping and spitting helps, but not lately"  Togress Notes" entry ical record was dated ext progress note found 2 at 10:00 A.M. The Post fallResident ain dining room and fell. At they were attempting to assist with ambulation. If on assisting resident to ent currently on nary tract infection, sinus as were dated: 6/4/12 at st fallResident observed ment after investigation 12 at 10:00 A.M"Post as admitted to hospital				

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 69 of 70

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING  B. WING	00	COMPLETED 06/21/2012
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	AT TUDOR GARD			N MICHIGAN RD /ILLE, IN 46077	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	2:34 P.M., the Digiven the opportuadditional eviden progress notes from period between 1.  In an interview of the Director of N.	conference on 6/19/12 at irector of Nursing was unity to submit any ace/documentation of om nursing staff for the 2/30/11 and 5/31/12.  In 6/21/12 at 11:45 A.M., tursing indicated she y nursing progress note			

State Form Event ID: PPKH11 Facility ID: 012263 If continuation sheet Page 70 of 70